REMARKS OF

THE HONORABLE

HENRY A. WAXMAN,

CHAIRMAN,

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

BEFORE

THE AMERICAN HOSPITAL ASSOCIATION

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HENRY A. WAXMAN, CHAIRMAN
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I'M GLAD TO BE HERE WITH YOU TODAY AND TO HAVE THIS BREAK FROM THE FURNITURE MOVING AND THE RUSH AS THE NEW ADMINISTRATION AND THE 97TH CONGRESS GET UNDERWAY. IT'S SOMETIMES STRANGE TO WATCH THIS TOWN AS EVERYONE STRIKES THEIR FIRST POSES AND GETS AN IMAGE TOGETHER. THE FUR COATS AND THE JEWELS AND THE LASER BEAM SEARCH LIGHTS -- IT'S ALL HERE NOW.

BUT THE MASTER OF STATUS SYMBOLS REALLY WAS LYNDON JOHNSON. BACK WHEN HE WAS SENATE MAJORITY LEADER, JOHNSON HAD ONE OF THE FIRST CAR TELEPHONES IN TOWN AND HE USED TO GET IN THE CAR AND PICK UP THE PHONE AND CALL PEOPLE TO SAY "THIS IS LYNDON JOHNSON. I'M JUST ON MY WAY INTO TOWN AND I THOUGHT I'D CALL." EVERYBODY WAS IMPRESSED.

EVERYBODY EXCEPT EVERETT DIRKSEN, WHO WAS THEN THE MINORITY LEADER. HE WAS TIRED OF THESE IMPRESSIVE CALLS. SO HE GOT HIMSELF A CAR PHONE AND THE FIRST CALL WAS TO JOHNSON'S CAR. HE CALLED ON HIS WAY TO WORK AND GOT JOHNSON AND SAID, "LYNDON, I'M JUST ON MY WAY INTO WORK AND I'VE GOT A NEW PHONE IN MY CAR AND I WANTED YOU TO GET THE FIRST CALL."

"EV," JOHNSON REPLIED, "I'M GLAD YOU CALLED AND I'D REALLY LIKE TO TALK BUT YOU'LL HAVE TO EXCUSE ME. MY OTHER LINE'S RINGING."

BUT DON'T LET THE SYMBOLS AND THE GLITTER GET IN YOUR EYES: THERE ARE GOING TO BE A LOT OF LATE NIGHTS THIS SPRING, BUT NOT VERY MANY OF US WILL BE DANCING TIL DAWN. THE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT, WHICH I CHAIR, HAS THIRTY-ONE HEALTH PROGRAMS AND THE CLEAN AIR ACT TO REVIEW AND REAUTHORIZE BY MAY 15TH. ADD TO THAT THE CHILD HEALTH ASSURANCE PROGRAM AND WHATEVER OTHER MEDICARE AND MEDICAID REFORMS WE MAY UNDERTAKE, AND YOU CAN SEE THAT IT'S GOING TO BE A VERY BUSY SEASON.

BUT BEFORE I GO FURTHER WITH THE PLANS AND PROGRAMS, LET ME GIVE YOU A SHORT OUTLINE OF THE CONGRESSIONAL COMMITTEES AND THEIR FIELDS. I AM A MEMBER OF THE COMMITTEE ON ENERGY AND COMMERCE, FORMERLY CALLED THE INTERSTATE AND FOREIGN COMMERCE COMMITTEE, THE OLDEST OF THE HOUSE COMMITTEES AND CERTAINLY THE ONE WITH THE BROADEST JURISDICTION, INCLUDING ENERGY, COMMUNICATIONS, CONSUMER PROTECTION, HEALTH AND THE ENVIRONMENT. ALTHOUGH FEDERAL HEALTH PROGRAMS WERE SMALL UNTIL TWENTY YEARS AGO, FEDERAL REIMBURSEMENT AND GRANT PROGRAMS HAVE MADE THE HEALTH SUBCOMMITTEE ONE OF THE BUSIEST IN CONGRESS. WE HAVE MAJOR JURISDICTION OVER ALMOST ALL HEALTH MATTERS, RANGING FROM MEDICAID TO THE FOOD AND DRUG ADMINISTRATION TO THE COMMUNITY MENTAL HEALTH PROGRAM. THE HOUSE WAYS AND MEANS COMMITTEE ALSO HAS [redacted] JURISDICTION OVER MEDICARE BECAUSE OF ITS CONTROL OF TAXATION AND THE SOCIAL SECURITY TRUST FUND, BUT ITS ROLE IS LIMITED TO THESE SPECIALLY FUNDED PROGRAMS.

ON THE SENATE SIDE, THINGS ARE DIVIDED UP A BIT DIFFERENTLY AND THERE ARE TWO COMMITTEES THAT DEAL WITH HEALTH: THE FINANCE COMMITTEE, WHICH CONTROLS REIMBURSEMENT LEGISLATION, AND THE

COMMITTEE ON LABOR AND HUMAN RESOURCES, WHICH CONTROLS THE GRANT PROGRAMS FOR HEALTH. WORKING WITH THE LABOR AND HUMAN RESOURCES COMMITTEE, MY COMMITTEE LAST YEAR PRODUCED THE COMPREHENSIVE REVISION OF THE COMMUNITY MENTAL HEALTH PROGRAM, WHICH MANY OF YOU NOW KNOW AS THE MENTAL HEALTH SYSTEMS ACT. WORKING WITH THE FINANCE COMMITTEE, MY COMMITTEE DREW UP MANY OF THE REIMBURSEMENT REFORMS WHICH WERE LATER INCORPORATED INTO THE BUDGET RECONCILIATION ACT. THERE ARE NEW CHAIRMEN AT EACH OF THESE COMMITTEES NOW, SENATOR HATCH AND SENATOR DOLE REPLACING SENATOR KENNEDY AND SENATOR LONG. WHILE SOME OF THE LEADERS IN THE ADMINISTRATION AND CONGRESS ARE NEWCOMERS, TO ONE EXTENT OR ANOTHER, TO THE HEALTH FIELD, I EXPECT THEY WILL FIND, AS I HAVE, THAT THE PROBLEMS OF HEALTH AND HOSPITALS ARE NOT ESPECIALLY PARTISAN PROBLEMS AND NONE OF THE PROBLEMS WILL BE EASILY SOLVED.

I AM CONCERNED THAT SOME SOLUTIONS THAT ARE BEING BANDIED ABOUT ARE SHORT-SIGHTED AND MAY BE CONSIDERED ONLY FOR THEIR FISCAL CONSEQUENCES. THE BUDGET LOOMS OVER ALL HEALTH PROGRAMS AND THAT MAY MEAN EVEN MORE HARD TIMES FOR THE INSTITUTIONS YOU REPRESENT.

I HAVE HEARD SOME PEOPLE CLAIM THAT IN LIGHT OF OUR FISCAL PROBLEMS, THIS NATION CAN NO LONGER AFFORD PUBLIC GENERAL HOSPITALS.

I BELIEVE THAT WE CANNOT AFFORD TO LOSE THE FEW PUBLIC HOSPITALS WE HAVE LEFT.

THESE FACILITIES PLAY A VITAL ROLE IN OUR NATION'S HEALTH CARE SYSTEM. THEY ARE SOURCES OF CARE FOR THE POOR AND THE UNDOCUMENTED. THEY ARE EMPLOYERS IN THEIR COMMUNITIES. AND THEY ARE THE BEST EDUCATORS OF OUR HEALTH PROFESSIONALS.

BUT AS YOU ARE ACUTELY AWARE, I'M SURE, MANY OF THESE PUBLIC HOSPITALS ARE EXPERIENCING FINANCIAL HARD TIMES AS A RESULT OF THEIR COMMUNITY SERVICE POLICIES. IN MY OWN STATE OF CALIFORNIA--WHERE COUNTIES HAVE A LEGAL OBLIGATION TO PROVIDE HEALTH CARE TO THE POOR--THE NUMBER OF COUNTY GENERAL HOSPITALS HAS DECLINED FROM 64 IN 1966 TO 39 IN 1980. THE FACILITIES THAT ARE LEFT IN RURAL AREAS ARE OFTEN THE ONLY SOURCE OF CARE AVAILABLE AND ARE ALMOST ALL NEAR-BANKRUPT.

THE CAUSES FOR THESE FINANCIAL PROBLEMS ARE CERTAINLY FAMILIAR TO YOU:

RISING OPERATING COSTS;

THE LARGE NUMBER OF PERSONS WHO ARE UNINSURED OR UNDER-INSURED;

A SHORTAGE OF CAPITAL TO RENEW PHYSICAL PLANTS;

SEVERE CONSTRAINTS ON STATE AND LOCAL TAX BASES;

DIFFICULTIES IN RECRUITING STAFF;

AND, IN SOME CASES, INEFFECTIVE MANAGEMENT.

MOREOVER, FEDERAL AID PROGRAMS HAVE THEMSELVES CREATED NEW PROBLEMS. EVEN WHEN PATIENTS ARE ELIGIBLE FOR MEDICAID, PUBLIC HOSPITALS HAVE TROUBLE COVERING THE COSTS OF PROVIDING CARE BECAUSE SOME STATES HAVE PLACED UNREALISTICALLY LOW LIMITS ON HOSPITAL COVERAGE UNDER THEIR PROGRAMS.

IT IS THE UNFORTUNATE FACT THAT WHEN HOSPITAL INFLATION RATES GO AS HIGH AS 19% AND PUSH THE OVERALL INFLATION RATE CONSTANTLY HIGHER, HCFA AND THE STATES WILL DO ALMOST ANYTHING TO RESTRAIN COSTS AND MANY OF THEIR POLICIES ARE SET UP IN AN ARBITRARY WAY TO DO ONLY THAT. FOR EXAMPLE, A NUMBER OF STATES WILL NOT PAY FOR MORE THAN 20 DAYS OF INPATIENT CARE PER YEAR, REGARDLESS OF MEDICAL NEED. WHERE SUCH LIMITS APPLY, THE PUBLIC GENERAL HOSPITALS MUST PROVIDE TREATMENT TO MEDICAID PATIENTS SOLELY AT THEIR COST.

AND EVEN WHEN MEDICAID DOES REIMBURSE, THE FORMULAS USED--SUCH AS THE CALCULATION OF DEPRECIATION ON OLD PHYSICAL PLANTS--OFTEN WORK TO THE DISADVANTAGE OF THE PUBLIC HOSPITALS THAT NEED AID THE MOST.

THESE PROBLEMS ARE CERTAINLY NOT NEW. MY COLLEAGUE, CONGRESSMAN RANGEL, AND THE WAYS AND MEANS COMMITTEE HAVE DONE MUCH TO UNCOVER THEM AND TO EXAMINE THE FEDERAL PARTS OF THE PROBLEM AND THE FEDERAL OBLIGATION TO FIND SOME SOLUTIONS.

THIS OBLIGATION IS CLEAREST WHEN WE TALK ABOUT THOSE PEOPLE WHO ARE FEDERALLY INSURED. PUBLIC HOSPITALS ARE--IN MANY CASES--THE LYNCHPIN IN THE MEDICARE/MEDICAID PROGRAMS BECAUSE THEY

OFFER THE ONLY SOURCES OF MEDICAL CARE. IN AREAS WHERE THERE ARE FEW PHYSICIANS OR CLINICS AND WHERE PRIVATE HOSPITALS WON'T ACCEPT PUBLIC PATIENTS, TO LOSE PUBLIC GENERAL HOSPITALS WOULD BE TO ABANDON THE FEDERAL COMMITTMENT TO THE POOR, THE ELDERLY, AND THE DISABLED.

I ALSO BELIEVE THAT THE FEDERAL GOVERNMENT HAS A CLEAR OBLIGATION TO ASSIST PUBLIC HOSPITALS BECAUSE A LARGE NUMBER OF THE PEOPLE SERVED THERE--THE UNDOCUMENTED ALIENS-- ARE THERE BECAUSE OF FEDERAL POLICY. IT IS THE FEDERAL IMMIGRATION POLICY WHICH ALLOWS UNDOCUMENTED PERSONS TO WORK AND LIVE HERE. BUT IT IS NOT FEDERAL POLICY TO ASSIST THOSE ORGANIZATIONS WHICH CARE FOR THE WORKERS ONCE THEY ARE HERE. I HAVE LONG FELT IT GROSSLY UNFAIR TO SHIFT WHAT I BELIEVE IS PRIMARILY AN OBLIGATION OF THE FEDERAL GOVERNMENT TO THE LOCALITIES AND PUBLIC GENERAL HOSPITALS.

BUT BEFORE I GO ON ABOUT FEDERAL PROGRAMS, I WANT TO EMPHASIZE THAT THIS OBLIGATION IS NOT FEDERAL ALONE. HISTORICALLY, STATES AND LOCALITIES HAVE HAD A LEGAL AND MORAL RESPONSIBILITY TO PROVIDE HEALTH CARE TO THE POOR -- A RESPONSIBILITY WHICH OFTEN TOOK THE FORM OF A PUBLIC GENERAL HOSPITAL.

WHILE IT IS NO LONGER REALISTIC TO EXPECT ALL STATE AND LOCAL TAX BASES TO COVER THE FULL COSTS OF SUCH AN OPERATION, IT IS EQUALLY UNREALISTIC TO EXPECT THAT THE FEDERAL GOVERNMENT WILL DO SO EITHER, PARTICULARLY IN THE CURRENT CLIMATE OF BUDGETARY RESTRAINT IN SOCIAL WELFARE PROGRAMS.

BUT STATES AND LOCALITIES COULD DO MORE FOR THEIR PUBLIC GENERAL HOSPITALS:

STATES COULD REFORM MANAGEMENT AND DELIVERY SYSTEMS.

STATE MEDICAID POLICIES COULD BE MODIFIED TO CONSIDER THE SPECIAL PROBLEMS OF PUBLIC GENERAL HOSPITALS.

STATES COULD PROVIDE ADDITIONAL DIRECT FINANCIAL SUPPORT.

AND I WOULD URGE STATES AND LOCALITIES TO CONSIDER USING THEIR TAX STRUCTURES MORE CREATIVELY AND TO ACHIEVE THE PUBLIC INTEREST BY PRIVATE MEANS. I'VE HEARD IT SUGGESTED, ALTHOUGH I'M NOT RECOMMENDING IT NOW, THAT TAX BODIES MAY WISH TO RE-EVALUATE WHETHER HOSPITALS SHOULD GET A "CHARITY" TAX-EXEMPT STATUS IF THEY DUMP FINANCIALLY UNATTRACTIVE PATIENTS.

AND NOW THAT I'VE SUMMARIZED THE PROBLEMS, THE OBLIGATIONS, AND THE POSSIBLITIES FOR STATE ACTIONS, I WISH THAT I COULD BRING YOU A FEDERAL SOLUTION AS WELL.

BUT....I'M AFRAID THAT I CAN'T BE VERY OPTIMISTIC. THE NEW FISCAL AND POLITICAL CLIMATE IN WASHINGTON IS CHILLY, AT BEST.

Frankly
Realistically speaking,

IT IS UNREALISTIC TO EXPECT THE FEDERAL GOVERNMENT TO UNDERTAKE ANY COSTLY NEW INITIATIVES THAT MIGHT ASSIST PUBLIC GENERAL HOSPITALS--DIRECTLY OR INDIRECTLY--IN THE NEAR FUTURE. The Reagan admin. would oppose + Congress would not pass it.
~~WHILE I WOULD CERTAINLY HOPE THAT THE SUBCOMMITTEE WILL CONSIDER SUCH PROGRAMS--NATIONAL HEALTH INSURANCE, CHAP, OR ASSISTANCE TO FINANCIALLY DISTRESSED HOSPITALS--I SERIOUSLY DOUBT THAT THE CONGRESS AS A WHOLE WOULD ADOPT ANY SUCH PROPOSAL AT THIS TIME.~~

WE THEREFORE NEED TO EXAMINE CAREFULLY THE IMPLEMENTATION OF EXISTING AUTHORITIES AND PROGRAMS TO BE SURE THAT THE FEDERAL DOLLAR IS MAKING THE MOST EFFECTIVE CONTRIBUTION TO THE FINANCIAL SOLVENCY OF THE PUBLIC GENERAL HOSPITALS.

THE PUBLIC HEALTH SERVICE ACT CONTAINS A NUMBER OF AUTHORITIES THAT HAVE THE POTENTIAL--LARGELY UNREALIZED--TO ASSIST PUBLIC HOSPITALS IN MEETING THEIR COMMUNITY SERVICE MISSION.

A NUMBER OF THESE AUTHORITIES EXPIRE THIS YEAR OR NEXT, AND I WILL URGE THE SUBCOMMITTEE TO GIVE SPECIAL CONSIDERATION TO REFINEMENTS WHICH MIGHT AID PUBLIC GENERAL HOSPITALS. I WILL, OF COURSE, BE ASKING FOR YOUR ASSOCIATION'S AID AND SUPPORT IN THIS PROCESS, SO LET ME REVIEW SOME OF THE MAJOR PROGRAMS.

SECTION 1610 OF THE ACT AUTHORIZES GRANTS TO PUBLIC FACILITIES FOR CONSTRUCTION OR MODERNIZATION PROJECTS WHICH ARE TO AVOID HEALTH AND SAFETY STANDARD VIOLATIONS. EVEN THOUGH THE AUTHORIZATION LEVEL IS QUITE LIMITED--$50 MILLION FOR FISCAL 1981--NO FUNDS HAVE EVER BEEN APPROPRIATED FOR THIS PURPOSE.

SECTION 328 OF THE ACT AUTHORIZES GRANTS TO PUBLIC GENERAL HOSPITALS TO DEVELOP AND OPERATE AFFILIATED PRIMARY CARE CENTERS. ALTHOUGH THE PROGRAM HAS GREAT POTENTIAL TO PROVIDE COST-EFFECTIVE, AMBULATORY CARE TO UNDERSERVED GROUPS, THE ACTUAL AMOUNT APPROPRIATED FOR THIS YEAR IS ONLY $10 MILLION, ONLY A THIRD OF THE AUTHORIZED AMOUNT.

THE ACT ALSO AUTHORIZES FUNDS FOR THE NATIONAL HEALTH SERVICE CORPS. THE CORPS IS TO ASSURE THAT PRIMARY CARE PHYSICIANS AND OTHER HEALTH PROFESSIONALS ARE AVAILABLE IN UNDERSERVED AREAS, AND SOME PUBLIC GENERAL HOSPITALS RELY ON CORPS DOCTORS TO SERVE THE POOR.

UNDER CURRENT POLICY, HOWEVER, MOST PUBLIC GENERAL HOSPITALS MUST PAY BACK THE FEDERAL GOVERNMENT FOR THE SALARY AND ALLOWANCES PAID TO CORPS MEMBERS.

THIS PAYBACK POLICY SEEMS TO ASSUME THAT STATE OR LOCAL TAX FUNDS ARE AVAILABLE TO MOST PUBLIC HOSPITALS.

SINCE THIS ASSUMPTION HAS NO BASIS IN FACT, THE SUBCOMMITTEE INCLUDED IN ITS HEALTH MANPOWER BILL THIS LAST YEAR A PROVISION THAT WOULD ASSURE THAT PUBLIC GENERAL HOSPITALS WOULD BE TREATED THE SAME WAY AS PRIVATE, NONPROFIT FACILITIES WITH RESPECT TO THE CORPS. AS YOU KNOW, THE MANPOWER BILL DIED IN CONFERENCE LAST YEAR, BUT I WILL RE-INTRODUCE THIS LEGISLATION SOON, AND I TRUST THAT IT WILL BE APPROVED BY THE COMMITTEE AND THE HOUSE FAIRLY QUICKLY.

FINALLY, THE PUBLIC HEALTH SERVICE ACT ALSO AUTHORIZES FEDERAL SUPPORT FOR THE DEVELOPMENT OF HEALTH MAINTENANCE ORGANIZATIONS. TO DATE, ONLY ONE PUBLIC GENERAL HOSPITAL--THE CONTRA COSTA COUNTY HEALTH DEPARTMENT--HAS QUALIFIED AS AN HMO, ALTHOUGH SEVERAL OTHER APPLICATIONS ARE PENDING. THE HMO ACT IS ALSO ONE OF THE BILLS THAT THE SUBCOMMITTEE WILL BE ADDRESSING THIS YEAR, AND I WILL URGE THAT THE TREATMENT OF PUBLIC GENERAL HOSPITALS UNDER THE ACT BE CAREFULLY EXAMINED. IN SOME INSTANCES, REORGANIZATION OF THESE HOSPITALS AS HMOS MAY GREATLY IMPROVE THE COST-EFFECTIVENESS AND THE COMPREHENSIVENESS OF CARE.

THUS, AMONG THE PUBLIC HEALTH AUTHORITIES, WE SEE THE POTENTIAL FOR ~~DIRECT~~ some FEDERAL ASSISTANCE TO PUBLIC GENERAL HOSPITALS IN THE AREAS OF RENOVATION AND MODERNIZATION, PRIMARY CARE, AND DELIVERY IMPROVEMENT.

AS IMPORTANT AS THESE CATEGORICAL PROGRAMS ARE, THEY CANNOT MATCH THE FISCAL IMPACT OF THE MEDICARE AND MEDICAID PROGRAMS THROUGH WHICH MOST FEDERAL HEALTH SERVICE DOLLARS FLOW. OF THE ESTIMATED FY 81 OUTLAYS OF $60 BILLION ON HEALTH CARE SERVICES, MEDICARE AND MEDICAID WILL ACCOUNT FOR ROUGHLY $56 BILLION. CLEARLY, IF THE FEDERAL GOVERNMENT IS TO ASSIST PUBLIC GENERAL HOSPITALS IN A MEANINGFUL WAY, IT MUST ASSURE THAT MEDICARE AND MEDICAID DOLLARS ARE SPENT EFFECTIVELY.

WHILE I'VE ALREADY TOLD YOU THAT THERE ARE NO BIG, NEW PROGRAMS AROUND THE CORNER, THERE IS ONE RECENT MEDICAID DEVELOPMENT THAT SHOULD BE OF SOME BENEFIT TO PUBLIC HOSPITALS. AFTER SOME PRODDING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ANNOUNCED LAST JUNE THAT A 5-YEAR DEMONSTRATION PROJECT FOR A METROPOLITAN HOSPITAL IN HARLEM WOULD BE STARTED. UNDER THIS PROJECT, THE FACILITY IS TO ENROLL SOME 17,000 UNINSURED PERSONS IN A PREPAID, COMPREHENSIVE CARE PROGRAM.

AND LAST MONTH, THE DEAPRTMENT ANNOUNCED THREE ADDITIONAL DEMONSTRATION PROJECTS INVOLVING PUBLIC GENERAL HOSPITALS IN BOSTON, JACKSONVILLE, AND LOS ANGELES.

ALL OF THESE DEMONSTRATIONS INVOLVE CAPITATION REIMBURSEMENT, MANAGEMENT REFORMS, AND THE EXPANSION OF MEDICAID ELIGIBILITY TO PERSONS WHO ARE NOW WITHOUT COVERAGE.

WHILE THESE INITIATIVES ARE NOT AS BROAD IN SCOPE AS MANY OF US WOULD HAVE LIKED, I AM HOPEFUL THAT THEY WILL PROVIDE THE KIND OF EXPERIENCE AND DATA THAT WE IN CONGRESS WILL NEED TO DETERMINE WHAT FEDERAL FINANCIAL COMMITMENT IS NECESSARY TO PROVIDE HEALTH SERVIES TO UNDERSERVED GROUPS.

I WOULD LIKE TO CONCLUDE THESE REMARKS WITH A REQUEST TO YOU FOR ASSISTANCE.

IN THE CURRENT BUDGETARY AND POLITICAL CLIMATE, ALL OF THE CATEGORICAL AND ENTITLEMENT PROGRAMS I HAVE BEEN DISCUSSING ARE AT RISK -- BOTH IN THE AUTHORIZATION PROCESS, AND IN THE APPROPROPRIATIONS PROCESS.

THESE PROGRAMS ARE OF OBVIOUS IMPORTANCE TO THE PEOPLE YOU SERVE AND TO YOUR INSTITUTIONS. IF THEY ARE CUT BACK, DRASTICALLY ALTERED, OR ELIMINATED ALTOGETHER, THEN YOUR PATIENTS AND YOUR INSTITUTIONS MAY SUFFER.

I WOULD HOPE THAT, AS THE 97TH CONGRESS GOES ABOUT ITS WORK, THAT YOU WILL JOIN TOGETHER WITH THE OTHER CONSTITUENCIES OF THESE PROGRAMS -- THE POOR, ORGANIZED LABOR, CIVIL RIGHTS GROUPS, AND THE PUBLIC HEALTH PROFESSION -- AND EDUCATE THE MEMBERS ON THE NEED FOR A STRONG PUBLIC GENERAL HOSPITAL SECTOR.

WITHOUT THE ACTIVE INVOLVEMENT OF SUCH AN ALIANCE IN THE UPCOMING LEGISLATIVE PROCESS, THE FEDERAL GOVERNMENT MAY CHOOSE TO BE UNABLE TO AFFORD PUBLIC GENERAL HOSPITALS.